ARTMENT OF HEALTH AND HUMAN SERVICES
EALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 8

2. STATE: Texas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT: See Attachment
a. FFY 2000 $ -0-
b. FFY 2001 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
See attachment

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
See attachment

10. SUBJECT OF AMENDMENT: Amendment No. 573 - The amendment allows for the transfer of reimbursement methodology for Intermediate Care Facilities for the Mentally Retarded (ICF/MR) Services from Texas Department of Mental Health Mental Retardation to the Health and Human Services Commission

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Linda K. Wertz

13. TYPED NAME:
Linda K. Wertz

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
September 6, 2000

16. RETURN TO:
Linda K. Wertz
Health and Human Services Commission
Post Office Box 13247
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 12, 2000

18. DATE APPROVED: October 17, 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:
Calvin G. Cline

21. TYPED NAME: Calvin G. Cline

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:
* pen & ink change made per State's 9/20/00 request.

FORM HCFA-179 (07-92)

Instructions on Back

Attachment to HCFA-179 for
Transmittal No. 00-08, Amendment No. 573

Number of the Plan Section or Attachment	Number of the Superseded Plan Section or Attachment
Attachment 4.19-D	Attachment 4.19-D
Page 1	Page 1 (TN97-05)
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I. General

The Texas Department of Mental Health and Mental Retardation (TDMHMR) reimburses Texas Medicaid providers for Intermediate Care Facilities for the Mentally Retarded (ICF/MR) services provided to Medicaid recipients. At least annually, the Health and Human Services Commission (HHSC) determines prospective uniform reimbursement rates for non-state operated facilities according to the size of facility. At least annually, HHSC determines facility specific reimbursement rates for state-operated facilities.

II. Definitions

For the purposes of ICF/MR reimbursement, the following words and terms shall have the following meanings, unless the context clearly indicates otherwise:

A. **Cost Reports**. Any cost data or financial information submitted by a provider to HHSC. Cost reports will include all types of cost data requested by HHSC including the following.

1. **Direct Services Cost Report.** Annual report required by HHSC in which cost data related to direct services is submitted by all ICF/MR providers.
2. **Full Cost Report (state-operated facilities).** Cost data required by HHSC that includes all costs of providing services including direct care costs, administration, facility costs, and all other operating costs relevant to the provision of services.
3. **Special Cost Surveys.** Any special cost surveys conducted by HHSC.
4. **Comprehensive Cost Report (non-state operated facilities).** All information of the provider including but not limited to those cost components listed in section V.B.8.a-e of Attachment 4.19-D, ICF/MR.
5. **Representative. Sample.** For non-state-operated providers, a combination of business factors and statistical considerations will be used to determine that the sample fairly reflects the characteristics of the overall population of non-state operated providers. The appropriate sample size will be statistically determined using the estimated population proportion using the following factors:
   a. Business factors, such as ensuring that the

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sample size has appropriate representation of facility/program size, ownership type, location, provider size and client level of need/acuity, will be in the sample design in order to properly assess the individual rate setting parameters used in the model-based reimbursement rates.

b. The business factors will be balanced against the statistical analysis of the number of individuals served and the amount of program dollars expended in order to provide for a sample size that is cost effective.

B. Acronyms

1. **GAAP** - Generally Accepted Accounting Principles.
2. **GAAS** - Generally Accepted Auditing Standards.
3. **HCFA** - Health Care Financing Administration.
4. **OMB A-87**- Federal Circular from the Office of Management and Budget A-87.
5. **TDMHMR** - The Texas Department of Mental Health and Mental Retardation or its designee.
6. **HHSC** - The Health and Human Services Commission or its designee.

C. Other terms

1. **Allowable costs.** Allowable costs are expenses, both direct and indirect, that are reasonable and necessary, as defined in paragraphs a. and b., of this subsection, and which are required in the normal conduct of operations to provide ICF/MR services meeting all pertinent state and federal requirements.

   a. **Reasonable** refers to the amount expended. The test of reasonableness includes the expectation that the provider seeks to minimize costs and that the amount expended does not exceed what a prudent and cost-conscious buyer pays for a given item or service.

   b. **Necessary** refers to the relationship of the cost, direct or indirect, incurred by a provider in the provision of ICF/MR services. Necessary costs are direct and indirect costs appropriate in developing and maintaining the required standard of operation for providing consumer care in accordance with the provider agreement, and with state and federal regulations.

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pro rata basis if the proportion used for ICF/MR services is well-documented.

10. **Related-party transactions.** Allowable costs are those which result from arm's length transactions involving unrelated parties. In related-party transactions, the allowable cost is limited to the cost to the related party, either the actual purchase prices paid by the related party or to the usual and customary charges for comparable goods and services, whichever is less. Two or more individuals or organizations constitute related parties whenever they are affiliated or associated in a manner that entails some degree of legal control or practical influence of one over the other. This can be based on common ownership, past or present mutual interests in any type of enterprise, or family ties.
11. **Administrative Penalties.** Fines assessed as administrative penalties and costs or interest associated with such penalties are unallowable.
12. **Other Benefits.** Costs for which a consumer had Medicare Part A or B benefits, third-party payor benefits, vendor drug coverage, or any other benefits are unallowable.

IV. Cost Data

A. Cost Reporting

1. **Types.** There are four types of cost reporting required by HHSC:
   a. Full cost reports;
   b. Comprehensive cost reports for non-state operated facilities;
   c. Uniform direct services cost reports; and
   d. Special Cost Surveys.
2. Frequency.
   a. Full cost reports are completed by state-operated providers every year. State-operated facilities complete full cost reports on a state fiscal year basis.
   b. Comprehensive cost reports are completed by a representative sample of non-state operated providers at least every four years.
   c. Direct services cost reports, as specified in II.A.1. and II.C.2. of Attachment 4.19-D (ICF/MR), are completed by all non-state operated providers on an annual basis, based upon the

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provider's fiscal year.

d. Special surveys are completed as requested.

3. Integrity of cost data.

a. HHSC conducts desk reviews of all reported costs to ensure that the financial and statistical information submitted in the reports conforms to all applicable rules and instructions. The basic objective is to verify that each provider's reports:

(1) Display financial and statistical information in the format required by HHSC;

(2) Report expenses in conformity with HHSC's lists of allowable and unallowable costs, as defined in Section III of Attachment 4.19-D (ICF/MR); and

(3) Follow generally accepted accounting principles [except as otherwise specified in the lists of allowable and unallowable costs as specified in Section III.B. of Attachment 4.19-D (ICF/MR)], or as otherwise permitted in the case of governmental entities operating on a cash basis.

b. HHSC verifies the information by:

(1) Comparing each provider's reported costs to past patterns of expenditures for similar services, results of previous on-site audits, normal operating cost relationships, and industry average costs.

(2) Reviewing each provider's reported costs to search for reported unallowable costs, omitted allowable costs, and overstated or understated allowable costs.

(3) Checking for completion of required information, mathematical accuracy, and adjusting improperly prepared reports.

c. **Audits.** HHSC or their designee will conduct on-site audits of reported costs as necessary to verify the integrity of the cost data.

d. **Exclusions of Certain Reported Costs.** Providers are generally responsible for eliminating all unallowable expenses from the cost report. HHSC reserves the right to exclude any unallowable expenses included in the cost report and to exclude from the rate

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base any cost reports which do not reflect economic and efficient operation.

e. **Adjustments to Certain Reported Costs.** HHSC adjusts costs reported by providers to ensure that costs used in rate analysis are reasonable and necessary for the provision of long term care services. HHSC reserves the right to reduce or eliminate costs deemed excessive or unnecessary from individual cost reports and to place limits on particular categories of costs to ensure that they reflect economic and efficient use of resources.

1. **Fixed Capital Asset Costs.** Annual increases in fixed capital asset costs to be included in the rate base will be limited consistent with current Medicaid regulations, the Deficit Reduction Act of 1984 and the Consolidated Omnibus Budget Reconciliation Act of 1985.
2. **Occupancy Adjustments.** HHSC adjusts the facility and administration costs of providers with occupancy rates below a target occupancy rate. The target occupancy rate is the lower of:
   a. 85 percent or
   b. the overall average occupancy rate for contracted beds in facilities included in the rate base during the cost reporting periods included in the base.
3. **Revenue Offsets.** HHSC offsets against reported expenses certain types of non-operating revenues, after reasonable allowances for overhead costs. Types of revenues offset against costs include: income from beauty and barber shop operations, prior year over-payments, vending machine proceeds, gift shop receipts, and payment for meals by employees and guests. Interest income is used to offset working capital interest expense, not to exceed total interest costs. An exception is interest income from funded depreciation accounts or qualified pension funds, which is not treated as a revenue offset item. For facilities reporting

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central office overhead expenses, interest income is offset against interest expenses before the allocation of central office costs to individual ICFs/MR.

V. Reimbursement Determination.

TDMHMR reimburses Texas Medicaid ICF/MR providers for services provided to eligible consumers in ICF/MR facilities. The Health and Human Services Commission (HHSC) determines reimbursement rates at least annually for two types of facilities: state-operated and non-state operated.

A. **Rate Determination for State-operated Facilities.** HHSC determines reimbursement annually. State-operated rates are effective May 1, 1996. Rates are facility-specific, determined prospectively (with the inflators outlined in Section VI), cost related, and do not vary by size or level of need.

1. **Description of rate class.** The state-operated facility rate class consists of all ICF/MR facilities that are operated by TDMHMR.
2. **Determination of state-operated facility rates.** Eligible state-operated facilities are reimbursed in the following manner:
   (a) The rate for each facility's projected per diem cost is based on the total projected allowable costs for selected cost centers divided by the total days of service the facility delivered in the cost reporting period.
      (1) Rates for state-operated ICFs/MR are based on the most current available cost report.
      (2) Rates for newly certified facilities that have not operated long enough to have current available cost reports (as defined in section VA2(d) of Attachment 4.19-D, ICF/MR) will be based on a pro forma model. The model will be derived as follows:

      A six bed or less state-operated facility's rate will be the average of all similarly sized state-operated facilities per diem rates for that particular rate year.

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as of the date of initial certification.

2. **Rates effective date.** HHSC approves rates to be effective January 1st of each calendar year unless otherwise specified.
3. **Per diem rate**. Non-state operated facility rates include payment for a full 24-hours of ICF/MR services except as provided for in V.B.7 of Attachment 4.19-D (ICF/MR) regarding durable medical equipment and page 17 of Attachment 4.19-B (ICF/MR) regarding dental services.
4. **Levels of need.** Non-state operated per diem reimbursement rates will be differentiated based on consumer level of need and the facility class. The level of need system is a classification system that differentiates rates based on the needs of the individuals served.
   a. The level of need classification is based upon the Inventory For Client and Agency Planning (ICAP) service levels. Individuals are classified in the intermittent category if they have an ICAP service level of 7, 8, or 9; individuals are classified at a limited level if they have an ICAP service level of 4, 5, or 6; individuals are classified at an extensive level if they have an ICAP service level of 2 or 3; and individuals are classified as pervasive if they have an ICAP service level of 1.
   b. For individuals who have extraordinary medical needs or behavioral challenges, there is an opportunity to adjust the level of need to more appropriately reflect level of service needed. Individuals who receive 3 or more hours of nursing service a week are eligible to be moved to the next higher level of need category. An individual cannot move to the next higher level of need category for both a medical and behavior reason. For individuals who have dangerous behaviors that require 1:1 supervision at least 16 hours per day, a special category has been developed, pervasive plus. The levels of need are defined as follows:
      (1) intermittent- infrequent personal care and/or regular supervision is required to meet the consumer's needs;

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as facility administrator, clerical support and central office staff, management contract fees, professional service fees, contracted administrative staff, general liability insurance, interest expense on working capital, allowable advertising, travel and seminars, dues and subscriptions, office supplies, central office costs and other office expenses.

e. Professional consultation expenses including professional contracted services for non-direct care staff(e.g., Medical Director, consulting pharmacists).

9. **Data analysis.** For the initial model based rates, a representative sample determined by an independent consultant was chosen to include providers of different sizes, providers who serve individuals with different level of care needs, and geographic areas of the state. Both public and private non-state operated providers were chosen. Cost, financial, statistical, and operational information was collected during the site visits performed by an independent consultant. These data were collected from cost reports and the service providers accounting systems. The same process will be used with the rebasing sample. The panel reviews and analyzes the fiscal year 1996 state wage data, the fiscal year 1994 cost data and the fiscal year 1995 sample data from 17 ICF/MR service providers statewide. The base year is calendar year 1997. The rate year is each calendar year thereafter.

a. The level of need assessment criteria is used to identify ICF/MR consumers according to the level of resources needed to care for them. HHSC uses the level of need criteria with available cost data to calculate rates by level of need and facility size (see section V.B.4. of Attachment 4.19-D).

b. All non-state operated ICF/MR providers will be required to prepare and submit annual Fiscal Accountability Cost Reports (direct service wages, benefits, contract services, and staffing information). The state will use this information to compare direct service costs to direct service reimbursement and to determine if rates need to be rebased more

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frequently.

c. At least every four years, a more detailed analysis of current costs and operational information will be performed for a representative sample of non-state operated providers determined by an independent consultant. This data plus the fiscal accountability reports will be analyzed by HHSC and reviewed by a panel of experts and the public. Recommendations will be made to the HHSC regarding any needed changes to rate factors in the model based on this sample information.

10. **Annual adjustments.** Annual rates for the time period between the years that modeled rates are rebased are set (at January 1) by inflating the previous year's direct cost rates, and other costs inflated as a percentage of direct costs, by the PCE as defined in Section VI of Attachment 4.19-D (ICF/MR). These rates are uniform by class of facility and client level of need category, determined prospectively, and adjusted annually. There is no cost settlement.

11. **Rebasing the Non-State Operated Modeled Rates.** At least every three years, HHSC will rebase the non-state operated modeled rates using the following process:

a. HHSC will seek to obtain an independent consultant to conduct detailed analysis of cost and operational information for a representative sample of ICF/MR providers throughout the state in accordance with Texas Government Code, Chapter 2254, which provides a state agency with the authority to contract with a private consultant. This representative sample will be determined by the independent consultant. Comprehensive cost reports will be completed by all providers in the representative sample. All other providers will complete the direct services cost reports which will be used to ensure costs are covered that must be incurred by an economic and efficient ICF/MR provider.

b. Site visits will be made to each of the sample providers to collect cost data and discuss operations.

c. An advisory panel consisting of ICF/MR

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providers, advocates, and department personnel will analyze available information regarding historical costs arrayed according to the cost components in V. B. 8. of Attachment 4.19-D (ICF/MR), operational data and level of need assessment both from sampled survey and annual fiscal accountability cost reports. HHSC will use the analysis for adjusting the assumptions used in the models or rebasing the rates.

d. HHSC will recommend adjustments to rate factors, if required, based on the results of the analysis of the sample of cost and operational information. These adjustments and rate revisions will be completed according to the State Plan.

e. Revised rates, as well as the rationale supporting the rates, will be presented to the Commissioner of HHSC for final approval and implementation. The implementation of revised rates will be completed according to the State Plan.

C. **Experimental class.** HHSC may define experimental classes of service to be used in research and demonstration projects on new reimbursement methods. Demonstration or pilot projects based on experimental classes may be implemented on a statewide basis or may be limited to a specific region of the state or to a selected group of providers. Reimbursement for an experimental class is not implemented, however, unless the HHSC and the Health Care Financing Administration (HCFA) approve the experimental methodology.

VI. General cost inflation index.

A. **Inflation indices.**

For all ICF/MR programs, HHSC uses the Personal Consumption Expenditures (PCE)Chain-Type Index as its general cost inflation index. The PCE is a nationally recognized measure of inflation published by the Bureau of Economic Analysis of the U.S. Department of Commerce. To project or inflate costs from the reporting period to the prospective rate period, HHSC uses the lowest feasible PCE forecast consistent with the

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forecasts of nationally recognized sources available to HHSC at the time rates are prepared for public dissemination and comment. Annual increases in fixed capital asset costs to be included in the rate base will be limited consistent with current Medicaid regulations, the Deficit Reduction Act of 1984 and the Consolidated Omnibus Budget Reconciliation Act of 1985.

B. Specific inflation indices. **The specific indices that the department uses include the following:**

1. Wage and benefit inflation rates for state-operated ICF/MR employees are determined by the Texas Legislature and Department merit policy.
2. The medical care CPI-U is used as the inflation index for the state school ICFs/MR comprehensive medical cost center. To project costs from the reporting period to the prospective rate period, HHSC uses the lower of the two medical care CPI-U forecasts reported by Data Resources Incorporated and Wharton Econometric Forecasting Associates.
3. The PCE is used to inflate other expenses.

VII. Payment for dental services available to consumers of ICFs/MR. Payments for dental services as described in Item 15b of Appendix 1 to Attachment 3.1-A and Item 15b of Appendix 1 to Attachment 3.1-B for persons 21 years of age and older who reside in an ICF/MR will be based on Texas Health Steps (formerly EPSDT) policies, procedures, limitations and rates, will be obtained through the consumer's Medicaid card.

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